Service Name	**ASA COMMUNITY SUPPORT**
Setting	A community based service primarily provided in the home or an appropriate community based setting, however, services may occur in an office based setting.
Facility License	As required by DHHS Division of Public Health.
Basic Definition	ASA community support is a rehabilitative and support service for individuals with primary substance use disorders. Community support workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual to maintain abstinence, stable community living, and prevent exacerbation of illness and admission to higher levels of care. Service is not provided during the same service delivery hour of other rehabilitation services.
Service Expectations basic expectations for more detail see Title 471 chapter 20	• A substance use disorder (SUD) assessment completed by a licensed clinician prior to the beginning of treatment. • If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary. • All individuals will be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders. • A strengths-based assessment will be developed within 30 days by non-licensed or licensed individuals on the team. The assessment may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual. • The treatment/recovery plan will be individualized, integrating individual strengths and needs, considering community, family and other supports, stating measurable goals and specific interventions, and include a documented discharge and relapse prevention plan. The treatment plan will be completed within 30 days of admission, reviewed, approved and signed by the clinical supervisor. • Review and update of the treatment/recovery and discharge plan with the individual and other approved family/supports every 90 days or more often as medically indicated; approved and signed by the Clinical Supervisor, or other licensed person. • Provide active rehabilitation and support interventions with focus on activities of daily living, education, budgeting, medication compliance and self-administration (as appropriate and part of the overall treatment/recovery plan), relapse prevention, social skills, and other independent living skills that enable the individual to reside in their community. • Provide service coordination and case management activities, including coordination or assistance in accessing medical, psychological, psychiatric, social, education, transportation or other appropriate treatment/support services as well as linkage to other community services identified in the treatment/recovery plan. • Develop and implement strategies to encourage the individual to become engaged and remain engaged in necessary substance use disorder and mental health treatment services as recommended and included in the treatment/recovery plan. • Participate with and report to treatment/rehabilitation team on the individual's progress and response to community support intervention in the areas of

	relapse prevention, substance use disorder, application of education and skills, and the recovery environment (areas identified in the plan). • Provide therapeutic support and intervention to the individual in time of crisis. • If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the individual's transition back into the community upon discharge. • If the individual has a co-occurring diagnosis (MH/SUD), it is the provider's responsibility to coordinate with other treating professionals. • All staff are to be educated/trained in rehabilitation, recovery principles, and trauma informed care.
Length of Service	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual's ability to make progress on treatment/recovery goals.
Staffing	• Clinical direction (APRN, RN, LIMHP, LMHP, PLMHP, LADC, PLADC, Licensed Psychologist, Provisionally Licensed Psychologist, dual MH/SUD preferred) working with the program to provide clinical direction, consultation and support to community support workers and the individuals they serve. The clinical director will review individual clinical needs with the worker every 30 days. The review should be completed preferably face to face but phone review will be accepted. The review may be accomplished by the supervisor consulting with the worker on the list of assigned individuals and identifying any clinical recommendations. The clinical supervisor may complete the review in a group setting with more than one worker as long as each individual on the worker's case load is reviewed. • Direct care staff, holding a bachelor's degree or higher in psychology, sociology or a related human service field are preferred but two years of coursework in a human services field and/or two years of experience/training or two years of lived recovery experience with demonstrated skills and competencies in treatment with individuals with a behavioral health diagnoses is acceptable. • All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
Staffing Ratio	Clinical Supervisor to Community Support Worker ratio as needed to meet all clinical supervision responsibilities outlined above 1:25 Community Support worker to individuals served
Hours of Operation	24/7 Access to service during weekend/evening hours; in times of crisis, access to a mental health professional
Desired Individual Outcome	• The individual has met their treatment plan goals and objectives. • The precipitating condition and relapse potential is stabilized such that the individual's condition can be managed with decreased professional external supports and interventions. • Individual has alternative support systems secured to help the individual maintain stability in the community.
Admission guidelines	• There is an expectation that the individual has the capacity to make progress toward treatment goals. • The individual is assessed as meeting the diagnostic criteria for a substance related disorder (including SUD or substance-induced disorder), as defined in the most recent DSM as well as the dimensional criteria for admission. • The individual, who is identified to need Level 1 Dual Diagnosis Enhanced program services, is assessed as meeting the diagnostic criteria for a mental disorder as well as a substance-related disorder, as defined in the most recent DSM as well as the

	dimensional criteria for admission. • The individual has a substance dependence diagnosis with functional impairments in each of the following areas: activities of daily living, employment, education, and social skills which are the direct result of the diagnosis. The individual is assessed as meeting specifications in ALL of the following six dimensions. • Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL: At minimal risk of withdrawal, at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-D criteria. • Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS: None or stable, or receiving concurrent medical monitoring. • Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS: Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Dual Diagnosis Enhanced setting is required for SPMI Severely and Persistently Mentally Ill individuals. • Dimension 4: READINESS TO CHANGE: Has marked difficulty with, or opposition to treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The individual, therefore, needs a Level I motivational enhancement program. • Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences. • Dimension 6: RECOVERY ENVIRONMENT: Environment is dangerous and individual lacks skills to cope outside of a highly structured 24-hour setting.
Continued stay guidelines	It is appropriate to retain the individual at the present level of care if: • The individual is making progress but has not yet achieved the goals articulated in the treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals; • The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the treatment plan; and/or • New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.